

Washington State 2007-08 Health Professional Scholarship Program

*Program located at Washington State Department of Health
310 Israel Road SW ♦ PO Box 47834 ♦ Olympia, Washington 98504-7834*

APPLICATION PROCESS

The purpose of the Health Professional Scholarship Program is to provide scholarships to students training to be primary care health professionals. In return the student signs a Promissory Note agreeing to work in a designated health professional shortage area in Washington state for a minimum of three years.

First priority for the 2007-08 academic year program funds will be given to those applicants enrolled in **Undergraduate Nursing, Nursing Faculty, Dental, Dental Hygienist, and Pharmacist programs** who demonstrate a commitment to rural communities and underserved populations as outlined in the narrative portion of the application. Applicants from remaining eligible health professions (MD/DO, Physician Assistant, Nurse Practitioner, Midwife) will be considered based on available funds, applicant pool, and number of providers currently being funded by the program. Award decisions can be expected in June. **All applicants will be notified by mail whether or not they have been awarded a scholarship.**

Applications must include the required attachments. **Incomplete applications will not be processed.** Completed applications must be **postmarked** no later than **April 30, 2007** or **faxed by 5:00 p.m. on April 30, 2007.** *If you have enrolled in a program and have not received a letter of acceptance, you may still apply but must submit documentation of acceptance before funds will be awarded.*

If you have any questions regarding the application process, contact:

Email: healthprof@doh.wa.gov

Phone: (360) 236-2817 Fax: (360) 664-9273

Web site: www.hecb.wa.gov/health

Applications may be faxed or mailed.

2007-08 Health Professional Scholarship Program Guidelines & Terms of Agreement

ELIGIBILITY

To be eligible, the student must:

- Be accepted into or currently enrolled in an accredited program leading to eligibility for credentialing in Washington state as a physician, osteopathic physician and surgeon, pharmacist, licensed midwife or certified nurse-midwife, physician assistant, nurse practitioner, nurse faculty, dentist, dental hygienist, registered nurse, or practical nurse.
- Have completed prerequisite courses.
- Continue to make satisfactory progress within their academic program.
- Agree to provide primary care health care services in Washington state for a minimum of three years.
- Be a United States citizen.

If selected for scholarship funding you will not be eligible to apply for the Loan Repayment Program until you have completed the service obligation for scholarship.

SELECTION AND NOTIFICATION

Applicants will be selected for participation in the Health Professional Scholarship Program based on the following criteria but not limited to:

- Prior experience in a rural or shortage area, academic/humanitarian achievements, letters of recommendation, and academic standing.
- Commitment and experience in serving the medically underserved or shortage areas, as described in the narrative portion of the application.
- Preference is given for applicants with community sponsorship and support.
- All applicants will be notified by mail whether or not they are awarded the scholarship.

AWARD AND PAYMENTS

Although scholarship awards are intended to meet the tuition expenses of participants, they are based on availability of state-supported program funds that may not accommodate 100 percent of those expenses.

- The award amount shall not exceed the actual cost of education for the particular program.
- Award notices will be mailed to applicant with amount of award, payments by semester/quarter, and name of the student's program.
- Checks are mailed to the school approximately two weeks before the beginning of each semester/quarter.
- Student will need to confirm with school the process of how the funds are disbursed.

RENEWAL

- Recipients may renew the scholarship for a period of five years, if they are continually enrolled in an eligible program.
- Scholarship renewal is contingent upon availability of funds for that program year. (The renewal amount may or may not be the same as the initial scholarship amount or the previous year's renewal.)
- **Undergraduate nursing recipients must complete a new competitive application at each program level (i.e., LPN, BSN, MSN).**

SERVICE OBLIGATION

The Scholarship Program can require the recipient to fulfill their service obligation in approved positions in state-designated shortage areas with the greatest need at the time of program completion.

- The length of repayment is determined by the number of years the scholarship is received.
- Service Obligation is based on 40 or more hours per week and prorated for less than 40.
- Participants must serve in a rural or underserved urban area for a minimum of three years.
- The total scholarship amount paid shall be forgiven (canceled) for each payment period (quarter) in which the recipient serves until the entire repayment obligation is satisfied.
- Shortage area designations are determined by the Department of Health.

REPAYMENT

Participants who do not fulfill the terms of the Promissory Note will be considered in default and will owe a double penalty plus interest.

A recipient will be considered in default:

- If they do not complete a course of study leading to credentialing in Washington state as a primary care health care provider.
- If they serve less than the minimum three-year service obligation.
- If they do not serve in a designated shortage area (list included with application packet).

The program may waive, in full or in part, the obligation for service or its rights to recover financial damages if the program determines that failure to fulfill the service obligation was due to circumstances beyond the participant's control. *(An example would be physical impairment or mental impairment to the degree that the participant can no longer function in his/her assigned duties.)*

**It is your responsibility to read and understand these
Guidelines and Terms of Agreement.**

**If you have questions, please contact our office.
360-236-2816 or 236-2817**

Washington State 2007-08 Health Professional Scholarship Program Application

**Application Deadline: Must be postmarked no later than April 30, 2007
or faxed no later than 5:00 p.m. on April 30, 2007.**

Instructions: Print clearly in ink or type responses. Complete all sections.

Personal

1. Name: _____ 2. SS #: _____
Last Name First Name MI
3. Date of Birth: ____ / ____ / ____ 4. Driver's Lic. #: _____ State: _____
5. Current Address: _____
Street City State Zip
6. Permanent Address: _____
(If different from current address) Street City State Zip
7. Telephone: (____) _____ 8. E-Mail: _____
9. Career needs of spouse (if applicable): _____
10. Your Hometown: _____ Spouse's Hometown: _____
11. Ethnic Origin (*optional*): _____ 12. ☐ Male ☐ Female
13. U.S. Citizen: ☐ Yes ☐ No (*Must be U.S. Citizen to apply*)
14. Upon completion of training, do you have another service obligation? **Please note, program recipients cannot commit simultaneously to two service obligations.**
- ☐ Yes ☐ No If yes, provide details. ☐ NHSC ☐ IHS ☐ Military
- ☐ Other (specify): _____ Date of completion: _____

15. List three adults, including at least one relative, who are not students, who are living at different addresses, and who will know your address in the future. This information will be used in tracking recipients during the service repayment period.

A. Name of Reference One	() Phone	Relationship to you
Address	City	State Zip
B. Name of Reference Two	() Phone	Relationship to you
Address	City	State Zip
C. Name of Reference Three	() Phone	Relationship to you
Address	City	State Zip

Education

Complete those questions that apply.

1. Undergraduate School: _____ 2. GPA: _____
 3. Degree: _____ 4. Date Received: _____ 5. Years/credits completed: _____
 6. Graduate/Professional School: _____ 7. GPA: _____
 8. Degree: _____ 9. Date Received: _____ 10. Years/credits completed: _____

Program Information

1. Program enrolled in 2007/08: _____
 (MD/DO, Physician Assistant, Nurse Practitioner, Dentist, Registered Dental Hygienist, Pharmacy, Midwifery, Licensed Practical Nurse/Associate Degree in Nursing, Registered Nurse, Bachelors of Science in Nursing, Masters of Science in Nursing, PhD in Nursing)
 2. School you will be attending 2007/08: _____
 3. School address: _____

 Street City State Zip

Program Information – Continued

4. Program start date: _____ Class level in school (2007-08): _____
5. Will you be considered a: ☐ Full Time Student ☐ Part Time Student
6. Are you applying for this scholarship to become nursing faculty? ☐ Yes: ☐ No
If yes, you must complete Question #6 in the Personal/Professional Experience section of this application.
7. Expected date of graduation/program completion: Month: _____ Year: _____
8. Degree/certification expected: _____ Expected License: _____
9. *Indicate the terms and number of credits for which you plan to enroll during the 2007-08 academic year:* **Fall** _____ (# credits) **Winter** _____ (# credits)
Spring _____ (# credits) **Summer** _____ (# credits)
10. Will your tuition be covered by another program or tuition waivers? ☐ Yes: ☐ No
If yes, program name: _____
Amount provided: \$ _____ Time period covered: _____

Personal/Professional Experience

(Make brief, concise statements)

- 1. Summarize your work/training/practice experience. Comment specifically on your experiences in rural/underserved urban areas.**

- 2. Describe your long-range personal and professional goals.**

Personal/Professional Experience – *continued*

3. **Discuss your volunteer/professional community service and how it relates to your commitment to serve in a designated rural area/underserved population upon completion of your program.**
4. **Describe life experiences you feel make you a good candidate for this scholarship. Include such things as multicultural experiences, languages in which you are fluent, hobbies, interests, etc.**
5. **Describe your academic/professional achievements that are of particular relevance to this program.**

Personal/Professional Experience – *continued*

6. If you plan to become nursing faculty, complete this section.

NURSING FACULTY: Describe your plans to teach nursing in a Washington State undergraduate nursing program and identify the institution in the spaces provided below.

Institution: _____ Name of contact: _____

Institution Address: _____
City State Zip

Agreement

I certify that the statements made herein are correct to the best of my knowledge. I authorize the Health Professional Scholarship Program to maintain a record of this information.

I have read the Guidelines and Terms of Agreement and agree to comply with all conditions of the scholarship and understand that I incur an obligation to repay the conditional scholarship with penalty and interest, unless I serve for a minimum of three years as a primary care health care provider in a designated rural, underserved urban, or other health professional shortage area in the state of Washington. **I understand that, at the time of program completion, I can be required to complete my service obligation in the shortage area with the greatest need at that time.**

I agree to accept Medicare assignments and Medicaid patients.

Signature of Applicant: _____ Date: _____

Attachment Checklist

- Program Verification Form signed by the Dean or Program Director. **(Required)**
- Three recommendation letters from training supervisors/professional colleagues. **(Required)**
To be used in the review and selection process to determine experience and commitment in working with rural and underserved urban populations. Letters should be from community leaders, faculty, training supervisors, and/or professional colleagues who can attest to your knowledge, commitment, and ability to fulfill the scholarship obligation. Include with your application packet.
- Academic transcript(s). **(Required)** Photocopy acceptable.
Applicants who have completed a year or more of health professional education/training should submit transcripts only for those years. Applicants entering the first year of health professional education/training should submit undergraduate or prior college-level transcripts.
- Community Sponsor/Support Form signed by sponsor. **(If applicable)**
If you completed the Community Sponsor/Support Form, a signature is required to receive credit.

Mail or Fax Completed Application and Required Attachments No Later Than 5:00 p.m. April 30, 2007 To:

Health Professional Scholarship Program
Office of Community and Rural Health
310 Israel Road SW
PO Box 47834
Olympia, WA 98504-7834

Fax: 360-664-9273

For information contact program staff at:

Telephone: 360-236-2817 or 360-236-2816
E-Mail: healthprof@doh.wa.gov

Web Site Address: www.hecb.wa.gov/health

**APPLICATION MUST BE POSTMARKED OR FAXED
NO LATER THAN 5:00 P.M. APRIL 30, 2007**

Program Verification Form

This form is required and must be included in application packet.

To be completed by Dean or Director of Program

I hereby certify that _____ has applied to or is
Applicant's Name

officially accepted into the _____ Program at
Name of Program

this school and, if a continuing student is academically in good standing.

Student Status will be: ☐ Full Time ☐ Part Time

Signature of Dean/Director of Program

Date

Printed Name

Title

Institution Name

Mailing Address

City

State

Zip

() _____
Phone number

() _____
Fax number

Email Address

Submit completed form with application packet.

Community Sponsor/Support Form

Community Sponsor/Support is optional – however, preference will be given to applicants who obtain community sponsor/support. Leave blank if you are not sponsored or expected by a particular community.

- A community sponsor may be a rural hospital, a rural health care facility, a community clinic, or a local health care provider that can provide training or employment opportunities, and post-graduation employment.
- Support should be a financial commitment that may include education/living stipends, matching funds, or employment/training opportunities.
- If there is an individual who expects you to join his or her practice, please provide a name and contact number.

This section is intended to show a commitment to a community with a shortage of primary care health care providers. If this section is completed, it will be expected that the service obligation will be completed in this community.

1. Sponsor: _____
(Clinic, hospital, physician, etc.)

2. Name of contact: _____ 3. Title: _____

4. Phone: (____) _____ 5. Fax: (____) _____

6. Email Address: _____ 7. County: _____

8. Address: _____
City State Zip

Describe the type of support this sponsor will provide:

- ☐ Financial Support. Describe: _____
- ☐ Training Opportunities. Describe: _____
- ☐ Employment. Describe: _____
- ☐ Other. Describe: _____

Sponsor Certification: *I hereby certify the above information is correct and the applicant is or will be receiving the support described above.*

Signature of Sponsor/Representative

Date

State of Washington
Health Professional Scholarship
Shortage Areas
January 2007
Facilities

Health Professional Scholarship recipients may locate at any of the following in Washington:

- State Correctional Facilities
- State Mental Health Hospitals
- Community and Migrant Health Centers (Federally-Qualified Health Centers)
- Any other facility (public, non-profit, or private) with more than 40 percent of its caseload consisting of Medicaid and sliding-fee discount schedule patients.
- Any facility listed in a shortage area for your profession

All scholarship recipients must be employed in direct primary care and not in a specialty clinic.

Shortage Areas by Profession

Nursing:

- There are no geographic restrictions for practical or registered nurses at this time.
- Nursing educators must work a full-time equivalent in a combination of faculty and clinical positions in Washington state. Faculty positions must be in a Washington state undergraduate nursing program that is experiencing a critical shortage of qualified faculty.

Other Professions:

- Shortage areas for the other professions are listed in the following table divided between Western and Eastern Washington.
- *HSA's (Shortage areas) are based on zip codes surrounding a core health facility such as a hospital or local public health department. Example: Yelm is listed, but clinics in surrounding areas such as McKenna or Roy would be included in the service area. Another example: Ellensburg is listed but clinics in Kittitas or Vantage would also be included in the service area.

** (The University of Washington WWAMI Rural Health Research Center developed Health Service Area [HSA] boundaries.)*

HEALTH PROFESSIONAL SCHOLARSHIP SHORTAGE AREAS

January 2007-08

Western Wash. *Health Service Areas	MD/DO	DDS	RDH	RX	PA	NP	MW		Eastern Wash. *Health Service Areas	MD/DO	DDS	RDH	RX	PA	NP	MW
Arlington					PA	NP	MW		Brewster		DDS	RDH				
Centralia		DDS		RX	PA	NP	MW		Chewelah	MD/DO	DDS	RDH	RX			
Concrete	MD/DO		RDH	RX	PA	NP	MW		Clarkston	MD/DO	DDS	RDH		PA	NP	MW
Darrington		DDS							Colfax					PA	NP	MW
Eatonville	MD/DO	DDS	RDH	RX	PA	NP	MW		Colville				RX			
Enumclaw			RDH	RX	PA	NP	MW		Coupeville		DDS	RDH	RX	PA	NP	MW
Forks		DDS	RDH	RX	PA	NP	MW		Davenport		DDS					
Gold Bar	MD/DO	DDS		RX	PA	NP	MW		Dayton	MD/DO	DDS					
Key Peninsula					PA	NP	MW		Deer Park	MD/DO	DDS	RDH	RX	PA	NP	MW
Longview				RX	PA	NP	MW		Ellensburg				RX			
McCleary	MD/DO	DDS	RDH	RX					Ephrata	MD/DO	DDS	RDH		PA	NP	MW
Monroe					PA	NP	MW		Goldendale		DDS	RDH	RX	PA	NP	MW
Morton		DDS	RDH	RX	PA	NP	MW		Grand Coulee			RDH	RX	PA	NP	MW
Mount Vernon				RX	PA	NP	MW		Ilwaco	MD/DO	DDS	RDH	RX			
North Bend	MD/DO	DDS		RX	PA	NP	MW		Ione/Metaline Falls	MD/DO	DDS	RDH	RX	PA	NP	MW
Olympic Peninsula			RDH		PA	NP	MW		Leavenworth		DDS		RX	PA	NP	MW
Orting	MD/DO	DDS	RDH	RX					Moses Lake				RX			
Port Angeles					PA	NP	MW		Newport	MD/DO	DDS	RDH	RX	PA	NP	MW
Port Townsend				RX	PA	NP	MW		Odessa		DDS	RDH		PA	NP	MW
San Juan Islands				RX	PA	NP	MW		Omak			RDH		PA	NP	MW
Shelton	MD/DO	DDS	RDH	RX	PA	NP	MW		Othello	MD/DO	DDS	RDH	RX	PA	NP	MW
South Bend	MD/DO	DDS	RDH	RX	PA	NP	MW		Pomeroy	MD/DO						
Sumas/Mt. Baker	MD/DO	DDS	RDH	RX	PA	NP	MW		Prosser	MD/DO	DDS	RDH	RX	PA	NP	MW
Yelm	MD/DO		RDH	RX					Pullman		DDS					
MD/DO Physician DDS Dentist RDH Registered Dental Hygienist Rx Pharmacist PA Physician Assistant NP Nurse Practitioner MW Midwife Nursing, all levels See previous page									Quincy	MD/DO	DDS		RX	PA	NP	MW
									Republic	MD/DO		RDH	RX	PA	NP	MW
									Ritzville	MD/DO		RDH	RX	PA	NP	MW
									Sunnyside			RDH	RX	PA	NP	MW
									Tonasket		DDS	RDH	RX			
									Toppenish		DDS	RDH	RX			
									Wenatchee					PA	NP	MW
									White Salmon	MD/DO	DDS	RDH	RX	PA	NP	MW